# DIVISION OF CHILD BEHAVIORAL HEALTH SERVICES

In-Community Mental Health Rehabilitative Services

PROVIDER PROFILE INFORMATION

*DATE COMPLETED:* _____

Name: _____

Mailing Address: _____

Phone #: _____

Email address: _____

Fax #: _____

## GEOGRAPHIC AVAILABILITY:

(Please check all counties where you would provide these services)

| | | | |
|---|---|---|---|
| Atlantic | _____ | Bergen | _____ |
| Burlington | _____ | Camden | _____ |
| Cape May | _____ | Cumberland | _____ |
| Essex | _____ | Gloucester | _____ |
| Hudson | _____ | Hunterdon | _____ |
| Mercer | _____ | Middlesex | _____ |
| Monmouth | _____ | Morris | _____ |
| Ocean | _____ | Passaic | _____ |
| Salem | _____ | Somerset | _____ |
| Sussex | _____ | Union | _____ |
| Warren | _____ | | |

## AGES SERVED:

(Please check all that apply)

0-5 _____
5-10 _____
11-17 _____
18-21 _____

| **SPECIALIZATIONS:** *(Please check all that apply; for each specialization checked, applicants **MUST** specify modality, training model, and/or specific certification/training in support of the assertion of specialization)* | **ASSESSMENT** | **TREATMENT** |
|---|---|---|
| Mental illness/developmental disability: | | |
| | | |
| Fire Setting: | | |
| | | |
| Eating Disorders: | | |
| | | |
| Sexual Abuse Victim: | | |
| | | |
| Detention Centers: | | |
| | | |
| Complex Trauma: | | |
| | | |
| Infant Mental Health/<br>Infant Parent Psychotherapy: | | |
| | | |
| Family Therapy: | | |
| | | |
| Parent Training/Skills Building: | | |
| | | |
| Treatment Home Provider: | | |
| | | |

## CULTURAL COMPETENCIES:

(Please list; EG: Bicultural expertise; Immigration; Gay, Lesbian, Bi-Sexual, Transgendered, Questioning, or Intersexed youth)

_____
_____
_____
_____
_____

## LICENSURE/CERTIFICATIONS:

Licensure _____
License # _____
DCBHS Needs Assessment _____
DCBHS Strengths and Needs Assessment _____
OTHER (Please List) _____
_____
_____
_____

## LINGUISTIC COMPETENCIES:

Languages Spoken:

(Please check all that apply)

Spanish _____ French _____
Portuguese _____ Other-specify _____

I _____ *(name, title, and* credential) certify that the information above is an accurate and true representation of the professional abilities of me and/or my agency to provide Intensive In-Community services in the localities, to the ages, and with the specialization(s) I have indicated. I understand that misrepresentation to the Division of Child Behavioral Services (DCBHS) of my or my agency's specialization, training, and/or geographical commitment will result in action by the DCBHS.